TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AMERICAN SPECIALTY PHARMACY

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-15-3977-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose is writing this letter is to inform you that on behalf of Worker Compensation Department at American Specialty Pharmacy, We have reached out to **Texas Department of Insurance (TDI)** regarding an outstanding bill for pharmacy services that were provided to you by us have not been resolved yet. It is our intent to pursue payment on an outstanding balance for the services rendered. Doing so, TDI may contact you in the near future with a schedule appointment for when this hearing will take place. No action is required on your part, the Workers Compensation Department at American Specialty Pharmacy will do its best to resolve this matter with TDI."

Amount in Dispute: $44.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns services provided by American Specialty Pharmacy associated with date of service April 21, 2014. As explained in the carrier's explanations of benefits, reimbursement was properly denied. Furthermore, the request for medical dispute resolution is not timely.

Under Division Rule 133.07(c)(1)(A), a Request for Medical Fee Dispute Resolution must be provided within one year of the date of service. American Specialty requested medical dispute resolution for date of service April 21, 2014. It does not appear the medical fee dispute resolution request was made until August 10, 2015. Accordingly, the date of service at issue is outside of the one-year deadline and the Division lacks jurisdiction to consider this disputes."

Response Submitted by: ACE/ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2014	Pharmacy Services	$44.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
   - 267 – Please submit a copy of your license or certification number for further review
   - 5261 – Letter – Please see additional reason codes outlining action needed from provider for further consideration of payment
   - W3 – Additional payment made on appeal/reconsideration
   - 5246 – In order for us to process your workers compensation bill in a timely manner we need additional information. Be sure the following are on your submittal for review and/or payment. Pharmacy NCPDP# (Formerly NABP#), prescribing doctor's name. Prescribing doctor's DEA#, RX Number, Days supply
   - 5261 – Letter – Please see additional message codes for information related to this review

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the service in dispute is April 21, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 10, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/11/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.